



Clark County  
Regional Support Network

**Vendor Agency**  
**Sentinel Event Thirty-Day Standard Review**  
REQUIRED FOR ALL REPORTED EVENTS

**CONFIDENTIAL**

Please submit the following information **within 30 days** of the sentinel event. **Attach Medical Examiner's report**, if available, or submit when received with copy of this report attached. Use additional sheets as necessary.

DATE OF EVENT: \_\_\_\_/\_\_\_\_/\_\_\_\_ CONSUMER ID #: \_\_\_\_\_

REPORTING AGENCY: \_\_\_\_\_ CONSUMER NAME: \_\_\_\_\_

MEDIA INVOLVEMENT: ☐ No ☐ Yes (describe) \_\_\_\_\_

DESCRIPTION OF EVENT:

☐ Homicide ☐ Attempted Homicide ☐ Suicide ☐ Attempted Suicide ☐ Unexpected or Suspicious Death  
☐ Injury ☐ Damage to Property ☐ Threat ☐ Assault ☐ Abuse or Neglect ☐ Loss of Services  
☐ Other \_\_\_\_\_

ATTENDANCE AND DATE OF AGENCY STANDARD REVIEW COMMITTEE, IF CONVENED:

\_\_\_\_\_  
\_\_\_\_\_

IF STANDARD REVIEW COMMITTEE DID NOT MEET, GIVE METHOD OF REVIEW OF EVENT, INCLUDING DATES AND STAFF NAMES AND TITLES:

\_\_\_\_\_  
\_\_\_\_\_

AGENCY ACTION RESULTING FROM COMMITTEE REVIEW: *(Please check all that apply)*

☐ Performance improvement activity not indicated: *(reason)*: \_\_\_\_\_

PLEASE LIST QUALITY OF CARE AND/OR SYSTEM ISSUES IDENTIFIED IN THE REVIEW:

\_\_\_\_\_  
\_\_\_\_\_

☐ QI study or project to be implemented: *(Describe and cite timeframes for start and completion)*

\_\_\_\_\_  
\_\_\_\_\_

STAFF TRAINING CONDUCTED OR PLANNED: ☐ YES ☐ NO *(If YES, cite topic and date)*

\_\_\_\_\_  
\_\_\_\_\_

WHO TRAINED: ☐ Individual ☐ Group ☐ Both ☐ Other action undertaken *(Please describe)*

\_\_\_\_\_  
\_\_\_\_\_

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_/\_\_\_\_/\_\_\_\_

PRINT NAME: \_\_\_\_\_ TITLE: \_\_\_\_\_